

2342

CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>b.</u> Last <u>adkins</u>				4. DATE OF DEATH Month <u>Jul.</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31 - 1877</u>	
9. AGE (In years last birthday) <u>79 10/13</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Powellville, md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>James Hooper</u>				14. MOTHER'S MAIDEN NAME <u>Elyia Jane Bradford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09-6129</u>			
17. INFORMANT <u>Mrs. Rosalie J. Dillons</u> Address <u>Snow Hill, md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO (b) <u>Hypertensive Cardio-vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>5/10</u> , 19 <u>56</u> , to <u>2/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>312 E. Market St. Snow Hill, Md.</u> DATE SIGNED <u>2/15/57</u>							
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Thomas L. Jones, M.D.</u> <u>312 E. Market St. Snow Hill, Md.</u> <u>2/15/57</u>			
22. BURIAL, CREMATION, 22a. DATE THEREOF <u>Feb 16/57</u> REMOVAL (Specify)				22b. NAME OF CEMETERY OR CREMATORY <u>Whateoat Unity</u> <u>Snow Hill, md</u>			
22c. LOCATION (City, town, or county) _____ (State) _____							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Dennis</u> ADDRESS <u>Snow Hill, Md.</u>				24a. REC'D BY REGISTRAR <u>Elwyn C. Cooper</u> DATE <u>2/18/57</u>			
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N. Y.

BUREAU V. 3

FEB 18 1957

RECEIVED

2343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 Berlin (RURAL)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 Route #3			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CORA First E. Middle Brithingham Last				4. DATE OF DEATH Month 2 Day 25 Year 1957			
5. SEX F.m.		6. COLOR OR RACE A.A.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-1915	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTH PLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Cherry				14. MOTHER'S MAIDEN NAME Sally V. Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-26-5392		17. INFORMANT Charles Brithingham		Address Berlin, Md Rt #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Acute coronary thrombosis DUE TO (b) Essential hypertension DUE TO (c) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 16 hrs 1 1/2 yrs 1 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/26 , 19 55 , to 1/22 , 19 57 , that I last saw the deceased alive on 1/22 , 19 57 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ivory V. Sully M.D.				ADDRESS (Street, city or town, state) Flower St Berlin Md			
DATE SIGNED 2/25/57							
PHYSICIAN'S NAME (Type) Ivory V. Sully							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-1957		22c. NAME OF CEMETERY OR CREMATORY African Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Cheriton, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart				ADDRESS Funeral Home Salisbury, Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
				DATE MAR 5 1957		Kelen F. Hayward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU

MAR 4

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Itme 12 Fil-0210 2-11-57 et

2340

CERTIFICATE OF DEATH

02354

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Pocomoke City,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Ginn</u> Middle <u>Collins</u> Last				4. DATE OF DEATH <u>February</u> <u>2</u> <u>1957</u> Month Day Year			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Mary Pitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah Marshall</u>		Address <u>Stockton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X</u> DUE TO <u>Tuberculosis of the Lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>D.K.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> <u>1957</u> , to <u>Feb. 1st.</u> <u>1957</u> , that I last saw the deceased alive on <u>Feb. 1st.</u> <u>1957</u> , and that death occurred at <u>6 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. <u>Pocomoke City, Md.</u>		ADDRESS (Street, city or town, state) <u></u>		DATE SIGNED <u>Feb 2 3 57</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>2/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
CERTIFICATE OF DEATH

BUREAU V. S.

FEB 8 1957

RECEIVED

2344

CERTIFICATE OF DEATH

Reg. Dist. No. 358-

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. LENGTH OF STAY IN 1b 14 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 1 BROAD ST			
3. NAME OF DECEASED (Type or print) First Middle Last ELLA TOWNSEND CROPPER				4. DATE OF DEATH Month Day Year FEB 23 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1870		9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD. R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOSIAH TOWNSEND				14. MOTHER'S MAIDEN NAME LETITIA VAN DOGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address MR. SIDNEY CROPPER NEWARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dilated Heart 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Hypertension & arteriosclerosis DUE TO (c) Age							INTERVAL BETWEEN ONSET AND DEATH 1/2 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1956 , to Feb 23, 1957 , that I last saw the deceased alive on Feb 23, 1957 , and that death occurred at 4:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. R. Low M.D.				ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED Feb 23-1957			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/25/57		22c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES		22d. LOCATION (City, town, or county) (State) NEWARK MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Busbagg ADDRESS Berlin Md.				24a. REC'D BY REGISTRAR DATE 2/25/57		24b. REGISTRAR'S SIGNATURE Stelan + Stayward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 3

FEB 26 1957

RECEIVED

2345

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>BERLIN (RURAL)</u>				c. LENGTH OF STAY IN 1b <u>All her life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>Ellen</u> Last <u>Cutler</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>F.M.</u>		6. COLOR OR RACE <u>A.A.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WORK</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George R. Hammond</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Selby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09-5895</u>		17. INFORMANT <u>Mrs PAULINE C PARNELL - Berlin, Md, Rt #5</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Essential hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>23</u> <u>Several yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. H. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/4</u> 19 <u>56</u> , to <u>2/21</u> 19 <u>57</u> , that I last saw the deceased alive on <u>2/21</u> 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>2/23/57</u>							
ACTUAL SIGNATURE <u>Ernest H. Sully, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Berlin, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin (Rt #2) Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home</u>				24. REC'D BY REGISTRAR <u>Salisbury, Md</u>			
25. REGISTRAR'S SIGNATURE <u>Helene F. Raymond</u>				DATE <u>MAR 5 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. 2

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02357 350

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 BERLIN RFD.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>CHANGY TOWN</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES H. DENNIS</u>				4. DATE OF DEATH Month Day Year <u>FEB 16 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8, 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN PLANT</u>		11. BIRTHPLACE (State or foreign country) <u>PITTSBURGH PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.N.</u>	
13. FATHER'S NAME <u>JOHN DENNIS</u>				14. MOTHER'S MAIDEN NAME <u>MAY BROOKMAR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-26-3542</u>		17. INFORMANT Address <u>Mr. IVAN DENNIS CHINGTEADGE VA</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Fracture, Cervical Spine - Fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2-3-4 x Rib Fract. Cont. & Comp. Chest.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Instantly to minute</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Neck in Collision, off Rt. 52, Completion Rt. Worcester Co.</u>					
20c. TIME OF INJURY Month, Day, Year <u>6:15 a.m. Feb 16 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>off Rt. 615.50</u>		20f. (City or town) (County) (State) <u>St. Martins Worcester Co. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Herman A. Robbins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Herman A. Robbins M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN (RFD. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burdige Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>2/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>Allen F. Hayward</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 20 1957

BUREAU V. A.

BUREAU OF



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02359

2348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH a. COUNTY <u>Morristown</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>20 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Morristown</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> <u>William</u> <u>Stillett</u> First Middle Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27-1904</u> 9. AGE (In years last birthday) <u>52/10/25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Safari</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Woods</u>	
11. BIRTHPLACE (State or foreign country) <u>New Church, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Stillett</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Spencer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Audrey Holland</u>		Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.9</u> DUE TO <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(?) accidental or homicide</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>Water</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. DATE OF REMOVAL (Specify) <u>Feb 24/57</u>		22b. DATE OF REMOVAL	
22c. NAME OF CEMETERY OR CRYPTORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>	
22e. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Davis</u>		22f. ADDRESS <u>Snow Hill, MD</u>	
23a. REC'D BY REGISTRAR		23b. REGISTRAR'S SIGNATURE <u>Edgar C. Casper</u>	
DATE <u>FEB 27 1957</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

RECEIVED

FEB 27 1957

BUREAU V. S.

2349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop c. LENGTH OF STAY IN 1b 30yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bishop		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop d. STREET ADDRESS Bishop e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Isaiah Harmon		4. DATE OF DEATH Month Day Year 3 Feb. 19	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 11, 1908 9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Isaac Parker		14. MOTHER'S MAIDEN NAME Martha Harmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-4351	
17. INFORMANT Ella Purnell, Bishop, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute endocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) After Nephritis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 430.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 14 - 1957 , to Feb 3 - 1957 , that I last saw the deceased alive on Feb 1 - 1957 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bishop, Md. DATE SIGNED 2-4-57 ACTUAL SIGNATURE Chas. P. [Signature] M.D. B. [Signature] NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6, 1957	22c. NAME OF CEMETERY OR CREMATORY Sarah Dukes	22d. LOCATION (City, town, or county) (State) Bishop, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR B 7 1957 24b. REGISTRAR'S SIGNATURE Edna R. Burgess	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 7 1957

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02362
350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> <input checked="" type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. LENGTH OF STAY IN 1b <u>minutes</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Market Street</u>			d. STREET ADDRESS <u>RED #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Peacock</u>			4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 16, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John H. Peacock</u>			14. MOTHER'S MAIDEN NAME <u>Ester Ann Ross</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-3594</u>		17. INFORMANT <u>Mrs. Alice E. Peacock, Pocomoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. a. O. I.</u> DUE TO <u>Chronic Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/25/57</u>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius Sr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 1 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

MAR 1 1957

BUREAU V. S.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2350

CERTIFICATE OF DEATH

Reg. Dist. No.

02363

357

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>31 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, MD x.?</u> d. STREET ADDRESS <u>203 Willow St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nellie K. Richardson</u> First Middle Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>F.M.</u> 6. COLOR OR RACE <u>A.A.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-2-1885</u> 9. AGE (In years last birthday) <u>72</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEASONAL WORK</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Shaper Kerner</u> 14. MOTHER'S MAIDEN NAME <u>Amy Ewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>219-03-768</u>		17. INFORMANT <u>Mr. Lee Richardson</u> Address <u>203 Willow St Snow Hill, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2/22/57</u> , 19____, to <u>2/27/57</u> , 19____, that I last saw the deceased alive on <u>2/26/57</u> , 19____, and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		104 Bay St SNOW HILL, Md.					
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>3-3-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Int. Zion Baptist Cemetery</u> 22d. LOCATION (City, town, or county) <u>Snow Hill, MD</u> (State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Stewart</u> ADDRESS _____ <u>Funeral Home, Salisbury, MD</u>		24a. REC'D BY REGISTRAR <u>Blayne Cooper</u> 24b. REGISTRAR'S SIGNATURE _____ DATE <u>3/1/57</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02364

2351

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1 PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Shackly</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>1957</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jul 1 - 1871</u>
9 AGE (In years, day, month, and year) <u>86 yrs</u>		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cum Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Stockton, md</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>George Brown</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Holland</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>Mar Nettie Hayden</u>		Address <u>Stockton, md</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia & Emaciation</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma of the Breast</u> DUE TO (c) <u>1 yr</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>54</u> to <u>Feb 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St</u> DATE SIGNED <u>2-23-57</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb 25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Snow Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Harris</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>Cheryl Cooper</u> 24b. REGISTRAR'S SIGNATURE <u>Cheryl Cooper</u>	

RECEIVED

FEB 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2352

CERTIFICATE OF DEATH

02365, 251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Attie</u> Middle <u>La</u> Last <u>Smach</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5 - 1899</u>
9. AGE (In years last birthday) <u>57 7/8</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Haler</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-7597</u>	
17. INFORMANT <u>Willma L. Smach</u>		Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia & Inanition</u> 1. <u>4X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno Carcinoma of Rectum</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo 3</u> <u>2 3/4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1, 1955</u> , to <u>Feb. 9, 1957</u> , that I last saw the deceased alive on <u>February 8, 1957</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. La Mar</u>		ADDRESS (Street, city or town, state) <u>104 Bay St Snow Hill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT G. LA MAR, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 11/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Worcester Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Danner</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR <u>FEB 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elwyn Cooper</u>	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 10 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2353

CERTIFICATE OF DEATH

02366

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	c. LENGTH OF STAY IN lb <u>77 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver M Sullivan</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11-1879</u>
9. AGE (In years last birthday) <u>77 1/2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State as foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William S. Riky</u>		14. MOTHER'S MAIDEN NAME <u>Emily Fleming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Jewell Stagg</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Breast - metastases</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>16 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1</u> , 1956, to <u>Feb 19</u> , 1957, that I last saw the deceased alive on <u>Feb 19</u> , 1957, and that death occurred at <u>9:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St</u> DATE SIGNED <u>2-20-57</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u>		M.D. <u>104 Bay St</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>		<u>Snow Hill, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb 21/57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Dennis</u>		24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>	
ADDRESS <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton Dennis</u>	

MARYLAND STATE OF HEALTH - BALTIMORE 18
 1-55-
 CERTIFICATE OF DEATH

BUREAU V. S.

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2354

CERTIFICATE OF DEATH

02367

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / Eden (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 21				d. STREET ADDRESS / R.D.# 21			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle KING Last WILSON				4. DATE OF DEATH Month February Day 10th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1872	9. AGE (In years last birthday) 84 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 12 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Wilson				14. MOTHER'S MAIDEN NAME Elizabeth Pusey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Elizabeth D. Wilson (Wife) Address R.D.# 2 Eden, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-6 , 19 57 , to 2-10 , 19 57 , that I last saw the deceased alive on 2-6 , 19 57 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. (Office) DATE SIGNED Feb. 11 1957							
ACTUAL SIGNATURE Earl L. Royer		M.D. Salisbury, Maryland					
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		M.D. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS 		24a. REC'D BY REGISTRAR DATE 2/14/57		24b. REGISTRAR'S SIGNATURE Mary Holloway	

CERTIFICATE OF DEATH

BUREAU V. 3

RECEIVED